SELF-ADMINISTRATION BY DOCTORS

(information for pharmacists)

*This summary has been prepared by the Drugs and Poisons Regulation Group (**DPRG**) to highlight concerns and issues associated with medical practitioners who self-administer Schedule 4 and Schedule 8 poisons. The DPRG website (www.health.vic.gov.au/dpu) contains summaries of other key requirements.*

Possibly suspicious behaviour

A number of medical practitioners (and dentists) have become drug-dependent due to self-administration of Schedule 4 and Schedule 8 poisons; especially pethidine ampoules, although morphine (ampoules and tablets), ketamine injections (previously S4 but now S8), midazolam (S4) and Panadeine Forte tablets have also been noted.

The following methods have been used to illegally obtain drugs for self-administration:

- Medical practitioners presenting prescriptions, written in patients' names, purportedly to deliver the medication, to make a house call or to replenish their Doctor's Bag stock.
- Medical practitioners presenting prescriptions written for a partner or other family member.
- Patients or clinic staff regularly collecting five pethidine ampoules, on prescriptions written in a patient's name, for "clinic use".
- Medical practitioners presenting prescriptions **forged** on prescriptions of other medical practitioners - sometimes after phoning the pharmacy in advance.
- Medical practitioners presenting prescriptions, with a mobile phone number on the form, and then leaving the pharmacy (to answer the phone and verify the prescription) before returning (as the patient) to collect the medication.

Reluctance to Report

Many pharmacists have failed to recognise the possible significance of such behaviour. Others have been suspicious but were reluctant to report the matter because they did not wish to get involved, were concerned about possible repercussions or did not wish to believe that a medical practitioner was involved in drug-seeking activities.

As these cases are all too frequent, DPRG Officers have considerable experience in discreetly investigating such matters and treat all reports of concern confidentially.

Urgency

Pharmacists should note that the described behaviour might only occur after a medical practitioner has been self-administering a drug for some months (often for a medical problem) and is just beginning to become dependent on the drug. However DPRG has noted that the use of pethidine ampoules can escalate very rapidly – often from 5 ampoules per month to **more than 10 ampoules per day** in less than 2 months.

Therefore, if a pharmacist observes behaviour of the type described, it is essential that the matter is promptly reported to DPRG to facilitate prompt intervention.

Preferred Outcome

When confronted by DPRG Officers, some medical practitioners are relieved to have been detected, promptly admit to their activities and place themselves in the care of the Victorian Doctors Health

Program (VDHP). Many are able to continue to practise, albeit with a number of restrictions, under the supervision of the Medical Practitioners Board of Victoria and/or ongoing health monitoring by the VDHP.

Examples of previous cases

- A medical practitioner presented scripts for five pethidine ampoules on 16 occasions at 15 pharmacies in 13 days. Several pharmacists later confirmed that they had been suspicious but only one contacted DPRG to report the matter. Others indicated that they had not thought (or had been reluctant) to contact DPRG in relation to a single prescription. Some indicated that they had been suspicious and had declined to dispense the script (saying it was "out of stock") but had not thought to notify DPRG.
- A medical practitioner (who rarely prescribed pethidine amps) returned to work following surgery and a lengthy rehabilitation. He subsequently began to prescribe pethidine amps with progressively greater frequency. The prescriptions were commonly presented at the same pharmacy (often by patients) but DPRG was not alerted until months later when the rate of prescribing had already reached ten amps per day.
- A medical practitioner (already prohibited from using Schedule 8 poisons due to a previous episode of self-administration) presented more than 120 forged scripts for pethidine ampoules at 16 pharmacies. More than 90 of the forgeries were successfully presented at three pharmacies where the forgeries were not detected. Six of the other pharmacies detected the forgeries (by phoning to verify the prescription) on the first or second occasion that a forgery was presented. The offender was eventually identified due to the actions of an alert pharmacist, who noted the licence plate number of the medical practitioner's car.
- An anaesthetist (already prohibited from using Schedule 8 poisons due to a previous episode of self-administration) obtained midazolam (S4) from various sources, including pharmacies attached to various major hospitals. The medical practitioner died from an overdose of drugs, including midazolam.
- A medical practitioner (already prohibited from using Schedule 8 poisons due to several previous episodes of self-administration) was found to have written prescriptions for a staff member at the clinic in order to obtain Panadeine Forte tablets. A perceptive pharmacist uncovered the ruse when counselling the "patient" about her medications.
- A medical practitioner, during the first of a number of episodes of self-administration, simply wrote prescriptions using her married name as the patient's name and represented herself as both the patient (when presenting prescriptions) and the prescriber (when pharmacists phoned to confirm that she had written the scripts).
- A medical practitioner's wife (who was well known at the pharmacies) was found to be self-administering pethidine ampoules that she obtained by presenting forgeries of her husband's scripts and collecting the pethidine supposedly to deliver it to the patient or to the surgery. Pharmacists assumed that the medical practitioner's wife was working or helping out at the clinic.

Other self-prescribing

DPRG has noted that many medical practitioners have prescribed Schedule 4 poisons (e.g. antibiotics, antidepressants) for their own treatment, without realising that they were contravening regulation 48 of the Drugs Poisons and Controlled Substances Regulations 2006. Pharmacists are asked to mindful of this situation and to not allow medical practitioners to inadvertently breach the legislation.

Prescribing for family members

Whilst the legislation does not prohibit medical practitioners from prescribing for their partners or other family members, the Medical Practitioners Board has indicated that it considers this practice (especially where drugs of dependence are involved) to be inappropriate in most circumstances. Pharmacists are asked to ensure that medical practitioners are aware of this.

Replenishing doctor's bag stock

A medical practitioner must not write a prescription (for a patient) to obtain drugs to replenish his/her doctor's bag. If additional drugs are required (i.e. more than the monthly PBS allocation) a medical practitioner may provide a handwritten order (specifying that the drugs are for surgery

use), which the pharmacist should treat as a **private** Doctor's Bag Order and record the supply in the name of the specific medical practitioner.

For further information

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